STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys 3/12/20 through 3/16/20. The survey was prompted by complaint intakes WY000003043, WY00003044, and WY00003045. The following common abbreviations are used throughout this document. BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MAR: Medication Administration Record MDS: Minimum Data Set PRN: Pro re nata (as needed) NHA: Nursing Home Administrator RN: Registered Nurse TAR: Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		8/13/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed 07/31/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 1 Based on observation, medical record review, resident and staff interview, review of wound clinic documentation, and policy and procedure review, the facility failed to provide wound care according to physician orders for 1 of 3 sample residents (#4) reviewed for wound care. In addition, the facility failed to follow nursing procedural guidelines for PICC (Peripherally Inserted Central Catheter) removal during one random observation, which affected resident #60. The findings were: 1. Review of the medical record showed resident #4 was admitted to the facility on 2/15/20 with diagnoses which included cerebral infarction, cellulitis of left lower limb and left toe, diabetes mellitus with foot ulcer and diabetic polyneuropathy, stage 3 pressure ulcer of left heel, peripheral vascular disease, obesity, stage 3 chronic kidney disease, long term (current) use of insulin, non-pressure chronic ulcer of other part of left foot with necrosis of bone, pressure-induced deep tissue damage of left heel, and unspecified open wounds of left lesser toes, left upper arm, left foot, and left lower leg. Review of the resident's care plan, last updated 3/12/20, identified the resident was at risk for skin impairment, including development of pressure ulcers. Interventions included keeping skin clean and dry, utilizing the hospital wound clinic for assistance and orders, monitoring dressings to ensure they were intact and adhering, providing treatment as ordered, and weekly treatment documentation, including measurements of each area of skin breakdown and its status at the time of treatment. Interview with the resident on 3/12/20 at 10:24 AM revealed s/he received wound care at the hospital clinic every Monday, and was supposed to receive dressing changes	F 684	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. The plan of correction serves as the facility□s allegation of compliance. F684 Quality of Care CORRECTIVE ACTION Resident #4 was discharge from the facility on 4/6/20. Resident #60 was discharge from the facility on 3/23/20. IDENTIFICATION OF OTHERS An audit was completed by 8/2/20 by the DON/designee of all residents with wound care orders to verify that each resident had the correct wound care orders on the TAR and that the orders were followed correctly. Any identified concerns were corrected Facility residents were audited to determine if any had PIC lines removed in the last 30 day on 7/30/20 by the DON/designee. No concerns were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 2 regularly in between visits. S/he also stated the wound care orders for dressings, treatments, and weight bearing status had changed and varied depending on how well the wounds were healing. The following concerns were identified: a. Review of the resident's physician orders, MAR, and TAR revealed no wound care orders from the day of admission to 3/3/20. A wound care order written on 3/3/20 showed. "Clean all wounds with wound cleaner and pat dry. L [left]. Posterior [back of] Knee: apply thin layer of Santyl [wound debridement ointment], cover with Xeroform [petroleum impregnated gauze], Mepilex [foam gauze with adhesive border] border and wrap with Kerlix [gauze wrap]. Change daily. Left Achilles, Left Lat [lateral] foot, and Left Heel: Clean with wound cleaner and pat dry. Apply Mepilex Border and change every 3 days and PRN. If you have any question regarding wound dressing PLEASE call [name] wound clinic. ([name] has Santyl if you run out) one time a day" This order was documented on the TAR as being performed on only 5 of 9 days from 3/3/20 to 3/11/20. A second order for wound care, ordered 3/10/20, showed: "Applied Silver foam [silver impregnated foam] to L posterior Knee. Applied Santyl, Xerofoam, Mepilex border, ABD [absorbent pad] heel cup and gauze wrap to L Achilles. Applied silver foam to Left heel and L lateral ankle with ABD heel cup and gauze wrap. Change every 3 days" This order was not documented on the MAR or TAR at the time of the survey. b. Review of documentation provided by the wound care clinic revealed information and communication from the clinic to the facility. This paperwork revealed notes referencing the resident's visit, orders, and notes of importance. Documentation from a 3/2/20 date of service	F 684	identified SYSTEMIC CHANGE In-service training was provided to the licensed nurses related to the proper process of following wound care orders and documenting wound care orders on the TAR by the SDC and completed by 8/2/20. The DON/designee reviews the orders on the MAR and TAR 5 days per week to verify all orders have been implemented and follow up is conducted if an omission is identified. DON was provided in-service education related to the use of an air occlusive dressing when removing a PICC line on 7/27/20 by the District Director of Clinical Services. The DON/designee observes 3 licensed nurses per week perform wound care to ensure that the procedure is performed in accordance with the physician□s orders. Any identified concerns are addressed at that time with the nurse. In-service education was provided to the licensed nurses by the SDC and completed by 8/2/20 related to the standard of practice related for PIC Line removal including the use of an air occlusive dressing. The DON/designee monitors the removal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 3	F 684		

showed: "...Applied santyl, xeroform, mepilex border and gauze wrap to L posterior knee and L achilles. Applied skin repair cream and mepilex border AG to L lateral foot. Applied mepilex border AG to Left heel and L lateral ankle with ABD heel cup and gauze wrap...Cheyenne Health Care Pt (patient) came to clinic today with no dressings on any of her wounds. PLEASE FOLLOW DOCTORS ORDERS. Apply all dressings as ordered above Santyl was sent with the pt. Apply a thin layer daily to L posterior knee and L Achilles then cover with xeroform, mepilex border and gauze wrap, do not use gauze wrap if it bunches up behind the knee. Other wound dressings to be changed every 3 days and PRN..." Documentation provided by the clinic confirmed this information was communicated to the facility via fax. Documentation from a 3/9/20 date of service showed: "...Applied silver foam to L posterior Knee. Applied santyl, xeroform, mepilex border, ABD heel cup and gauze wrap to L Achilles. Applied skin repair cream and ABD pad and gauze wrap to L lateral foot. Applied silver foam to Left heel and L lateral ankle with ABD heel cup and gauze wrap...Cheyenne Health Care Pt came to clinic today with some of the correct dressings on [his/her] wounds and some incorrect. PLEASE FOLLOW DOCTORS ORDERS. Also, please note changes from last week. Apply all dressings as ordered above. Santyl was sent with the pt. Apply a thin layer daily to L Achilles then cover with xeroform, mepilex border and gauze wrap. Silver foam to all other wounds-dressings to be changed every 3 days and PRN."

c. Observation of wound care performed by LPN #1 on 3/12/20 at 4:45 PM showed there was not a dressing to the resident's posterior knee. After all dressings had been removed, wounds of PIC Lines through observation of the technique and use of correct air occlusive dressing. Any identified concerns are addressed and corrected with the nurse. These observations will continue for 3 months.

MONITORING

The Director of Nursing reports any identified patterns or trends from the wound care observations to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These observations will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.

The Director of Nursing reports any identified patterns or trends from the observation of PIC Line removal to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These observations will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4	F 684		

were not cleansed and dried. Barrier cream was applied to the left Achilles (instead of Santyl), covered with Xeroform, and covered with a Mepilex. A Mepilex was placed on the left lateral heel; no silver foam was applied to any of the wounds on the left lateral heel or ankle, and no skin repair cream was applied to the left lateral foot. An ABD pad was placed around the heel, and then the whole foot was wrapped in gauze wrap. A large square Mepilex was cut into pieces and used to cover the wound on the back of the knee; no silver foam dressing was applied. The resident voiced his/her concerns and expressed errors in the care four different times during the treatment. The resident stated the dressings were incorrect and the treatment had changed. The nurse stated "This is all we have so this will have to do. We don't have what you're talking about."

d. Interview with the DON and the RN district representative at 2:16 PM on 3/13/20 revealed they were unaware the resident did not have the correct supplies for the wound care orders. The DON stated she had the extra cream, and the other supplies should be in the resident's room or in the supply closet.

2. Review of the medical record revealed resident #60 was admitted to the facility on 2/6/20 with diagnoses which included diabetes mellitus with foot ulcer and neuropathic arthropathy, methicillin susceptible staphylococcus aureus infection, peripheral vascular disease, cellulitis of left lower limb, anemia, essential hypertension, long term (current) use of insulin, and non-pressure chronic ulcer of unspecified heel, midfoot, and other part of left foot with unspecified severity. The resident was on Coumadin (an anticoagulant), and had a PICC (peripherally inserted central catheter) line in his/her left upper arm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5	F 684		

Observation on 3/12/20 at 3:22 PM showed the DON entered the resident's room wearing her gown and gloves and stated she had an order to remove the resident's PICC line. The resident was sitting in the Semi-Fowler's position (positioned sitting in bed with the head of the bed raised to between 15 and 45 degrees, with 30 degrees the most frequently used) with his/her arm lying on the bed at approximately a 45 degree angle from his/her side. The DON walked over and began removing the outer transparent dressing and PICC line stabilizing device that was beneath it. She held the resident's arm under the insertion site with her left hand, and started to withdraw the line with her right hand. She would remove a few inches, stop, ball the extracted line up into her right hand, re-grab the line, withdraw a few more inches, and continued this process until it was completely removed. She then applied a small square of dry gauze to the insertion site and wrapped the upper arm with elastic Coban wrap (a self-adherent wrap used to secure and protect wounds and dressings). She told the resident the wrap had to be a little tight, and to leave the wrap on for at least 10 minutes to stop the bleeding. She placed the discarded line into a biohazard bag and left the room.

a. Interview with the DON and the RN district representative at 2:16 PM on 3/13/20 revealed the DON had not reviewed the facility policy and procedure guideline prior to performing the PICC line removal. The DON stated she performed the task the way she was taught during nursing school. The RN district representative accessed the facility policy on her computer to verify the correct procedure. Neither the DON or RN district representative were aware of the need for an air occlusive dressing (a dressing applied to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6	F 684		

removal location to prevent air from entering the body through the open site that leads directly into the blood stream) after a PICC line removal.

b. Review of the facility policy and procedure entitled Lippincott Procedures showed Peripherally inserted central catheter (PICC) removal, last revised 6/14/19, included significant steps such as "...step 4) Confirm the patient's identity using at least two patient identifiers...step 5) Provide privacy...step 6) Explain the procedure to the patient and family (if appropriate) according to their individual communication and learning needs to increase their understanding, allay their fears, and enhance cooperation...step 9) Place the patient in a supine flat or Trendelenburg position (positioning so that the patient is somewhat inverted, with their feet and trunk elevated higher than their head), unless contraindicated, so that the insertion site is at or below heart level to prevent air embolism...step 14) Place a fluid-impermeable pad under the patient's arm...step 15) Instruct the patient in how to perform the Valsalva maneuver (a process of developing and maintaining pressure inside the body, achieved by taking a deep breath in and holding it, and bearing down during the procedure) during removal, unless contraindicated, to prevent air embolism (a blockage of a vein or artery caused by air bubbles that enter the bloodstream)...step 20) Apply gauze to the insertion site; with your dominant hand, slowly withdraw the catheter using gentle, even pressure, as shown below. If you meet resistance, don't forcibly remove the catheter because forcible removal can result in catheter fracture and embolization (a blockage by the fragmented catheter)...step 21) Have the patient perform Valsalva maneuver as you withdraw the final catheter segment to prevent air embolism. If

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 7 the Valsalva maneuver is contraindicated, use the Trendelenburg or left lateral decubitus position (positioning the patient on their left side while lying flat) or have the patient hold a breath, as applicable...step 22) After successful removal of the catheter, apply manual pressure to the site with a sterile gauze pad until you achieve hemostasis (stopping the flow of blood or bleed). (Guidelines recommend applying pressure for 1 to 5 minutes.)...step 23) Cover the site with a petroleum-based ointment and sterile dressing for at least 24 hours to seal the skin-to-vein tract and reduce the risk of air embolus...step 24) Assess the integrity of the removed catheter. Compare the length of the catheter to the original insertion length (as shown below) to ensure that you've removed the entire catheter. If you note damage, immediately notify the practitioner and monitor the patient for signs of catheter embolism (palpitations, arrhythmia, dyspnea, cough, and thoracic pain). Note that the patient may need to undergo a chest X-ray for further evaluation...step 26) Instruct the patient to remain in a flat or reclining position for at least 30 minutes after device removal to reduce the risk of air embolism..."	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters	F 692		8/13/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 8 of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to ensure interventions to prevent weight loss were followed in 1 random observation which affected resident #95. The findings were: 1. Review of the 10/14/19 significant change MDS assessment showed resident #95 had a weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months that was not a physician-prescribed weight-loss regimen. Review of the nutritional care plan showed an intervention of "Double portions per resident request" was initiated on 11/5/19. Further review showed the care plan was revised on 2/18/20 to "Encourage [resident name] to request large portions or second portions of foods enjoyed." Review of a "Nutrition Status Review" assessment dated 2/14/20 showed the resident had experienced weight gain which was "beneficial, desirable, and planned given prior h/o (history of) weight loss." The care plan remained current and the resident was to be offered double portions per his/her request. The following concerns were identified:	F 692	F 692 Nutrition/Hydration Status Maintenance CORRECTIVE ACTION Resident #95 tray card was reviewed on 5/19/20 by the Dietary Manager to ensure that his preferences were accurately communicated to the dietary staff at the time of service. IDENTIFICATION OF OTHERS On 7/31/20 the Registered Dietician reviewed the diet orders in the electronic medical record, tray cared information, preferences and care plan to ensure all were accurate. Any necessary updates were completed at the time of the audit. SYSTEMIC CHANGE Education was provided to the dietary staff regarding tray accuracy and honoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 9 a. Interview with the resident on 3/12/20 at 12:40 PM revealed s/he had requested an additional serving of chicken and had been told s/he would have to wait until all the residents in the facility had been served before a second portion could be offered and it might be over an hour before that would be determined. The resident stated "you come in here hungry and leave hungry." Observation at that time showed the resident had consumed 100% of the meal served. Review of the resident's diet card showed "Double Portions per [his/her] request." b. Interview with RN #1 on 3/12/20 at 12:49 PM revealed residents often ask for an additional portion and were told they would have to wait until everyone was served before the additional food could be offered. c. Interview with the contract district dietary manager on 3/13/20 at 10 AM revealed residents were asked to wait until everyone was served if an additional serving was requested. In addition, if the diet card stated "double portions at the resident's request" the CNA should have brought the diet card to the kitchen and then a "determination" would be made. d. Interview with RN #1 on 3/13/20 at 12 PM revealed she was unaware the resident's diet card needed to be returned to the kitchen. She stated if a resident was to receive double portions it should not be an issue.	F 692	resident preferences on 7/28/20 by Dietary Manager The Registered Dietician conducts an audit of 10% of the meal trays weekly to the resident preferences and care plan to ensure accuracy. If an error is identified it is corrected and additional training is provided to the staff member. The facility honors resident requests for additional portions when requested. Should the item be unavailable facility staff offer alternatives. The SDC provided in-service education to all staff who assist with dining regarding honoring choices for additional portions when requested and assisting residents with alternative choices should the item be unavailable prior to 8/13/20. The Dietary Manager provided in-service education to the dietary staff regarding honoring choices for additional portions when requested and assisting residents with alternative choices should the item be unavailable prior to 8/13/20. MONITORING The Dietary Manager reports any identified patterns or trends from the weekly tray/preferences/care plan audits to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These observations will continue for 3 months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 10	F 692	unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, wound clinic staff interview, and medical record review, the facility failed to ensure residents were free from significant medications errors for 1 of 3 sample residents (#97) reviewed. This failure resulted in harm to resident #97, who experienced a significant decline in wound status requiring admission to the hospital. The findings were: 1. Review of the medical record showed resident #97 was admitted to the facility on 12/31/19 with diagnoses which included end-stage renal disease, osteomyelitis, peripheral vascular disease, obesity, diabetes mellitus, polyneuropathy, dependence on renal dialysis, thrombocytopenia, anemia, and long term (current) use of anticoagulants and insulin. The resident had scheduled wound care appointments outside of the facility 1 to 2 times per week. The following concerns were identified: a. Review of a physician order dated 3/3/20 showed "Vancomycin 1G (gram) with every dialysis treatment. ([physician's name] will determine stop date in clinic tomorrow) Dx: heel wound infection, bilateral." Review of the March 2020 MAR showed an order for dialysis on	F 760	F 760 Residents are Free of Significant Med Errors CORRECTIVE ACTION Resident #97 was discharged from the facility on 3/10/20. The nurse who made the transcription error in the electronic record when ordering the medication received education from the SDC on 3/12/20. A medication variance report was completed related to this error on 3/10/20. IDENTIFICATION OF OTHERS An audit was completed on 8/2/20 of all physician□s orders in the last 30 days by the DON/designee to identify any order transcription errors. Any identified errors were corrected and a medication error form was completed.	8/13/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 11 Tuesday, Thursday, and Saturday. Further, there was a separate order written "Per [physician's name], Vancomycin 1G to be sent with resident to each dialysis appointment. [Physician's name] will determine stop time. every day shift every Tue, Thu, Sat Send with patient to Dialysis." b. Review of a nurse's note dated 3/10/20 and timed 5:48 PM showed "Resident missed 4 doses of vancomycin." Review of the March 2020 MAR revealed the first scheduled dose was to be given 3/5/20; the dose was documented as having been administered. The next dose was to be administered 3/7/20; this dose was documented as not given, with a reason of "Vitals outside admin parameter." No supporting documentation was identified to justify the failure to administer the medication. The third dose was scheduled to be administered 3/10/20; this dose was documented as not given because the resident was "Hospitalized." c. Interview with the DON on 3/13/20 at 1:25 PM revealed the facility only kept "a few over-the-counter medications" on hand for the residents if they needed them. Otherwise, a pharmacy was contracted to supply the correct medications after the facility called or faxed the orders in. The facility was unable to provide confirmation documentation that the pharmacy had been notified or provided the order for the vancomycin. d. Review of a nurse's note dated 3/10/20 showed the resident was admitted to the hospital for "...open wounds to the bilateral feet." e. Interview with the DON and the RN district representative at 2:16 PM on 3/13/20 revealed the facility's expectation for nurses when receiving new orders was to verify the order, place the order into the electronic health record correctly, and then fax the order to the pharmacy.	F 760	SYSTEMIC CHANGE In-service training was provided to the licensed nurses by the SDC and completed prior to 8/2/20 related to proper procedure for transcribing orders into the electronic heath record and notification of the pharmacy. The nursing administration team reviews all orders in the electronic record the following business day for accuracy and to ensure all steps in the process were correctly followed. Any identified issues are corrected at that time, and retraining is provided to the nurse if needed. The Unit Manager follows up with each resident appointment to identify any new orders. MONITORING The Director of Nursing reports any identified patterns or trends from the orders reviews, ordering medication from the pharmacy and follow up of new orders from appointments to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These orders reviews will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 12 The DON stated she was unsure why one dose of vancomycin was documented as being administered. She further revealed the facility did not have the medication on hand because it was never ordered from the pharmacy. f. Interview with wound care physician and the wound care clinic RN revealed they struggled with the facility and their nurses with "follow-through and implementation of the orders we send them on a regular basis." The physician revealed during the previous appointment on 3/3/20, the resident's wounds had gotten "considerably worse and looked infected, and that is why I consulted [consulting physician's name]." She also stated the consulting physician ordered the resident to be placed on the vancomycin, and for the antibiotic to be administered during the resident's dialysis appointments. The wound care physician stated that with the wound care she had performed, and with the additional antibiotics on board, the resident should have been doing much better; however, during the most recent appointment on 3/10/20, the resident's wounds had progressed "...so bad that we had to keep [resident's name]..." and the resident was directly admitted to the hospital. In addition, she stated the resident was scheduled for surgical debridement of both heels on 3/16/20.	F 760		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.	F 809		8/13/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809	Continued From page 13 §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, review of posted meal times, staff and resident interview, and wound clinic staff interview, the facility failed to ensure meals were served at times comparable to normal mealtimes in the community or in accordance with resident needs. The census was 96. The findings were: 1. Review of the posted meal times showed the assisted dining room began serving the morning meal at 7:15 AM; the noon meal at 11:15 AM; and the evening meal at 5:15 PM. The main dining room began serving the morning meal at 7:30 AM; the noon meal at 11:30 AM; and the evening meal at 5:30 PM. The following concerns were identified: a. Observation on 3/12/20 at 9:50 AM showed CNA #1 was distributing room trays to residents residing in the North hallway. The last room tray was delivered at 10:30 AM. Interview with CNA #1 at 10:13 AM revealed the facility served the assisted dining room first, the main dining room next, and then the room trays. Further, the noon room trays were usually delivered around 1 PM	F 809	F 809 CORRECTIVE ACTION The dietary staff was provided in-service education related to the times that the meal starts in each dining room as well as the time the room trays should be delivered to each wing by the Dietary Manager on 7/28/20. (Meal times have been extended due to significant increase in room trays during the COVID-19 pandemic). The dietary staff was provided in-service education related to the scheduled appointment list put out daily by the scheduler that provides scheduled pick up times. The dietary staff uses this schedule to identify residents who have appointments that conflict with meal time. The dietary staff makes and provides the meal around the scheduled appointment or sends them a sack meal. This training	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809	Continued From page 14	F 809		

and the evening trays were delivered around 7 PM.

b. Observation on 3/12/20 at 12:52 PM showed the room tray cart was delivered to the North hallway from the kitchen. The last room tray was delivered at 1:10 PM (approximately 2 hours and 45 minutes after the morning meal trays had been delivered).

c. Interview on 3/12/20 at 9:55 AM with resident #20 revealed s/he was afraid of people and preferred to have meals delivered to his/her room. Further s/he preferred to have meals at "normal" times.

d. Interview on 3/12/20 at 10:05 AM with resident #74 revealed the morning meal used to be delivered at 7:30 AM; however the facility had changed their system and now s/he did not receive breakfast until around 10 AM. The resident was observed in the main dining room for the noon meal at 12:40 PM.

e. Interview on 3/12/20 at 10:30 AM with resident #71 revealed s/he preferred breakfast be served around 8 AM; the noon meal around 12 PM; and the evening meal around 6 PM. In addition, s/he preferred to have his/her coffee first thing in the morning and having to wait "sucks".

f. Interview with resident #4 on 3/12/20 at 10:24 AM revealed s/he left the facility for an appointment at the wound care clinic at least once per week and the appointments were first thing in the morning. The resident stated it was difficult to get breakfast and be ready in time for the appointment. The resident was a diabetic, and revealed there had been times s/he had to skip breakfast since "...it isn't always ready on time." Although s/he could not remember the specific date, the resident revealed s/he was not able to get breakfast before the appointment, and was given "...a glass of orange juice covered in

was provided by the Dietary Manager on 7/28/20. (During the COVID-19 pandemic, meals are provided before/after appointment and eaten in the facility in order to comply with mask usage during outside appointments).

IDENTIFICATION OF OTHERS

All residents have the potential to be affected by a late meal.

All residents with appointments have the potential to be affected by a missed meal.

SYSTEMIC CHANGE

The dietary staff was provided in-service education related to the times that the meal starts in each dining room as well as the time the room trays should be delivered to each wing by Dietary Manager on 7/28/20. (Meal times have been extended due to significant increase in room trays during the COVID-19 pandemic).

The Dietary Manager/designee monitors the start time of each dining room and the delivery time of the room trays for 5 random meals per week to ensure proper timeliness of service. Any identified concerns are addressed with the service team and corrected.

The dietary staff was provided in-service education related to the scheduled appointment list put out daily by the scheduler that provides scheduled pick up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809	Continued From page 15	F 809		

aluminum foil and was sent on my merry way!"

g. Interview with resident #60 on 3/12/20 at 3:22 PM revealed s/he attended appointments at the wound care clinic, morning on a weekly basis. The resident stated s/he was diabetic and did not always get breakfast in the morning before having to leave for the appointment. The resident chose to eat meals in his/her room, even though it took longer to get the food. The resident also revealed s/he had gone to the appointment without being able to eat prior to departure, and "...the nurses at wound care have had to go get me food."

h. Interview on 3/13/20 at 8:34 AM with resident #73 revealed s/he went to the wound clinic twice a week; leaving the facility at 7:30 AM for an 8 AM appointment. In addition, s/he was supposed to have breakfast before leaving, however, that did not always happen.

i. Interview with the wound care clinic RN on 3/13/20 at 12:17 PM revealed staff at the wound care clinic had struggled with diabetic residents from the facility, both with wound healing and coming to appointments without eating. Further, there were two instances, one with resident #97 and one with resident #60, in which they had shown up to appointments and had not been served breakfast before leaving the facility. She personally went to the hospital cafeteria to get them food to prevent a hypoglycemic episode.

j. Interview with the contract dietary district manager on 3/13/20 at 10 AM revealed a list of scheduled appointments was given to the dietary department each day to ensure the residents received food before they had to leave for their appointments. In addition, he stated the cook's shift began at 5 AM.

k. Observation on 3/13/20 showed the room tray cart was delivered by the dietary department to the North hallway at 8:55 AM with the last

times. The dietary staff uses this schedule identifies residents who have appointments that conflict with meal time. The dietary staff makes and provides the meal around the scheduled appointment or sends them a sack meal. This training was provided by the Dietary Manager on 7/28/20. (During the COVID-19 pandemic, meals are provided before/after appointment and eaten in the facility in order to comply with mask usage during outside appointments).

The scheduler provides a copy of the following day□s appointment with pick up times to the kitchen each day. The kitchen staff uses this information to prepare early meals or meals on the go for those residents with appointments. The Dietary Manager/designee monitors 5 random meals per week to ensure that meals are provided to the residents with appointments. Any identified concerns are corrected.

MONITORING

The Dietary Manager reports any identified patterns or trends from the meal service timeliness audits to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These observations will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.

The Dietary Account Manager reports any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809	Continued From page 16 resident tray delivered at 9:20 AM. l. Interview with the contract dietary district manager on 3/13/20 at 10 AM revealed the facility had approximately 30 to 40 residents that preferred to have breakfast in their rooms. Further, in the past, the kitchen prepared the room trays first and then served the residents in the dining rooms. He stated this process caused the meal service in the dining rooms to be delayed so the decision was made to do the room trays after the residents in both dining rooms had been served. In addition, he stated the facility was encouraging residents to eat in the dining rooms instead of their rooms. m. Interview on 3/13/20 at 11:10 AM with the NHA revealed the facility used to prepare the room trays first; however "more and more" residents were requesting a room tray which "forced" the dining room to be late. She stated the system change was discussed with the resident council and all the residents were given a written notice. Further, the NHA revealed the scheduler made all the resident appointments and then compiled a list which was distributed to the kitchen. Further, she stated there was not a system to ensure the residents had received a meal and she was unaware there were any concerns.	F 809	identified patterns or trends from the missed meal audits to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These observations will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		8/13/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 17 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the scheduled appointment worksheets, resident and staff interviews, and review of the US Public Health Service Food Code, the facility failed to ensure food was maintained at the appropriate holding temperature for 2 of 2 sample residents (#32, #58) reviewed. The findings were: 1. Review of the 1/16/20 admission MDS assessment showed resident #32 was admitted to the facility on 1/10/20 with diagnoses which included end-stage renal disease, diabetes mellitus, and malnutrition or risk of malnutrition. Further review showed the resident had a BIMS score of 15/15 (cognitively intact); broken or loosely fitting dentures, and was prescribed a therapeutic diet. Review of the 3/2/20 through 3/12/20 "Schedule Appointment" worksheets showed the resident left the facility at 11 AM for an 11:20 AM appointment at the dialysis center on Monday, Wednesday, and Friday. The following concerns were identified: a. Interview on 3/12/20 at 11:15 AM with the resident revealed s/he had an appointment with the dialysis center 3 times per week at 12 PM. A	F 812	F 812 Food Procurement, Store/Prepare/Serve-Sanitary CORRECTIVE ACTION Resident #32 was discharged from the facility on 4/14/20. Resident #58 was discharged from the facility on 7/14/20. IDENTIFICATION OF OTHERS All residents who leave the facility for appointments with perishable food items have the potential to be affected by this practice SYSTEMIC CHANGE The dietary staff was provided in-service education by Dietary Manager on 7/28/20 related to the requirement of maintaining	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 18	F 812		

noon meal was provided for him/her by the facility to be consumed at the dialysis center. The resident stated s/he received either a turkey or ham sandwich; a whole apple which s/he could not eat because the apple needed to be cut up; and crackers which s/he should not eat because they were too salty. The food was packaged in a resealable plastic storage bag without any temperature control to keep the food at the correct temperature. Further, the resident stated the meal was consumed sometime after his/her dialysis treatment had been initiated.

2. Review of the 2/16/20 admission MDS assessment showed resident #58 was admitted to the facility on 2/9/20 with diagnoses which included end-stage renal disease and malnutrition or risk of malnutrition. Further review showed the resident had a BIMS score of 14/15 (cognitively intact), was prescribed a therapeutic and a mechanically altered diet. Review of the 3/2/20 through 3/12/20 "Schedule Appointment" worksheets showed the resident left the facility at 6:30 AM for a 7 AM appointment at the dialysis center on Tuesday, Thursday, and Saturday. The following concerns were identified:

a. Interview on 3/12/20 at 3:27 PM with the resident revealed the meal sent with him/her to dialysis that day included 2 turkey and cheese sandwiches, an orange, and cookies. In addition, the facility usually sent breakfast items with him/her and thought perhaps the facility had forgotten this time and had packed the meal at the last minute. The food was packaged in a resealable plastic storage bag without any temperature control to keep the foot at the correct temperature. The resident stated the food was kept unrefrigerated on his/her side table at the dialysis center and was consumed at

food at appropriate temperatures when sent with residents when they leave the facility with perishable food items. (During the COVID-19 pandemic, meals are provided before/after appointment and eaten in the facility in order to comply with mask usage during outside appointments).

The scheduler provides a copy of the following day□s appointment with pick up times to the kitchen each day. The kitchen staff uses this information to prepare meals on the go for those residents with appointments. When the meal leaves the kitchen it remains on ice to ensure that all perishable food remains safe to eat. The Dietary Manager/designee interviews 5 residents per week related to verifying meals on the go are sent with temperature control to keep the food at the correct temperature. Any identified concerns are corrected. (During the COVID-19 pandemic, meals are provided before/after appointment and eaten in the facility in order to comply with mask usage during outside appointments).

MONITORING

The Dietary Account Manager reports any identified patterns or trends of meals on the go being sent with temperature control from resident interviews to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These observations will continue for 3 months unless the Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 19 approximately 10 AM. 3. Interview with the contract district dietary manager on 3/13/20 at 10 AM revealed the morning cook prepared the meals for the residents according to the daily "Scheduled Appointment" list provided by the scheduler. Further, he verified the meals were sent with the residents in a non-temperature controlled container. According to Food Code 2017, U.S. Public Health Service: 3-501.16 "(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5ºC (41ºF) or less.	F 812	Assurance Performance Improvement Committee deems it prudent to continue.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		8/13/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20	F 880		

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 21 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure effective infection control practices were followed during 2 random observations which involved resident #4. The findings were: 1. Observation on 3/12/20 at 4:45 PM showed LPN #1 was providing wound care to resident #4. The resident had a wound behind his/her left knee and multiple wounds to his/her left foot. The wounds to the left foot had their own individual dressings which were covered by one large dressing of gauze wrap. The nurse began to unwrap the resident's outer gauze dressing. Beginning at the resident's toes he wadded the gauze up into his hand as he proceeded. Once he reached the area near the resident's heel, he assisted the resident by holding his/her leg up with his opposite hand and continued to unwrap the gauze. However, instead of wadding it up into his hand, he began wrapping it around his gloved hand. When the gauze wrap was removed, the	F 880	F 880 Infection Prevention and Control CORRECTIVE ACTION Resident #4 was discharged from the facility on 4/6/20. Education was provided to the nurse who conducted the would care to resident #4 related to wound care and infection control by the SDC on 7/13/20 Education was provided to the staff member who entered the resident #4□s room without the appropriate Personal Protective Equipment (PPE) by the SDC on 3/17/20. IDENTIFICATION OF OTHERS All residents who require wound care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22 nurse put his hand into the resident's full garbage receptacle to scrape and unwrap the gauze dressing from his hand. Without removing the contaminated glove he continued to remove the dressings on the resident's foot. He removed a small, adhesive-type dressing from the underside of the resident's foot, and this dressing stuck to his glove. The nurse again placed his hand into the garbage receptacle in an attempt to remove the dressing from the glove. Without removing his contaminated gloves the nurse continued to provide care to the resident's exposed wounds. 2. Observation on 3/12/20 at 10:22 AM showed nursing staff was placing resident #4's room on contact precautions. At that time RN #2 revealed it was due to the resident having symptoms of nausea, vomiting, and diarrhea. On 3/12/20 at 2:26 PM LPN #1 was observed entering the resident's room without applying a gown, gloves or a mask and then assisted the resident with positioning and set up for his/her meal tray. 3. Interview on 3/13/20 at 10:30 AM with the infection preventionist revealed it was the facility's expectation for staff to use a gown, gloves, and a mask when a resident was on contact precautions. In addition she stated if gloves were soiled for any reason they should be removed, hand hygiene performed, and new gloves donned. 4. Interview on 3/13/20 at 2:17 PM with the DON and the district consultant RN verified contaminated gloves need to be removed during wound care and new gloves donned if any contamination occurred. Further, clean gloves should be worn when new dressings were applied. In addition, personal protective	F 880	have a potential to be affected by this practice. All residents have a potential to be affected by a staff member not wearing appropriate PPE into a resident□s room who is on contact precautions. SYSTEMIC CHANGE Licensed nurses were provided in-service education related to infection prevention practices while providing wound care by the DON/Designee and completed on 8/2/20. The DON/designee observes wound care practices of random nurses 3 times per week, observing for proper infection control procedures. Any identified concerns are addressed and the nurse is provided additional education to correct the practice. Facility staff were provided in-service education related proper donning and doffing Personal Protective Equipment and when to use PPE and how to identify when to use PPE by the Infection Preventionist and completed prior to 8/2/20. The DON/designee observes 4 staff members per week donning and doffing PPE and interviews 4 staff members per week as to how to identify when to use PPE and what PPE is required. MONITORING	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 03/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23 equipment needed to be worn for all rooms with contact precautions, regardless of the length of time being spent in the room or if contact with the resident occurred.	F 880	The Director of Nursing reports any identified patterns or trends from the wound care observation and PPE observations/interviews to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These orders reviews will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	